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| Consent for Services |
| The undersigned hereby authorized the Doctor to take X-rays, study models, photographs, or any other diagnostic aids deem appropriate by Doctor to make a through diagnosis of the patient’s dental needs. I also authorize Doctor to perform and all forms of treatment, medication, and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I understand my dental insurance is a contract between me and the insurance carrier and not between the insurance carrier and the Doctor and that I am still fully responsible for all dental fees. These fees are due payable at the time of services are rendered unless prior financial arrangements have been made. I also assign all insurance benefits to the Doctor. Any payments received by the Doctor from my insurance coverage will be credited to my account, or refunded to me if I have paid the dental fees incurred. I further understand that a late charge will be added to any overdue balance. I understand that where appropriate, credit reports may be obtained.  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Patient:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Signature of Patient, parent or guardian  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Dentist Signature |

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| Office Billing & Insurance Policies |
| *Payments*  Payments are due the day of service are performed. Payment is accepted in the form of cash, debit cards, or credit cards (Visa, Mastercard, Discover or American Express). If you would like to keep am account on file with us, please fill in the appropriate information below.  *Insurance*  Your insurance plan is an agreement between your insurance company and you. We file claims to your insurance as a courtesy to you. After 30 days, we ask that you call your insurance company if no payment has been received. After 60 days, any outstanding insurance balance will be your responsibility. Also, please understand, you are responsible for the balance of charges incurred regardless of your insurance payment.  *Billing*  You may incur a finance charge of 1.5% on your account if your balance is not paid in 60 days or less. Please inform us of any financial concerns so an agreement can be made up front of how the account will be paid. I also agree that should it become necessary to forward my account to collections, in additions to the amount owed, I will also be responsible for the fees associated with the cost of collections.  *Authorization*  I have read and understand the above written financial policy; I hereby authorize payment of insurance benefits directly to Burnett Dental Care, otherwise payable to me. I understand I am ultimately responsible for all costs of dental treatment not covered by insurance.  Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| Health Information Privacy Policy Act (HIPPA) |
| Patient Name: |
| Guardians Name: |
| Phone Number: Work: Cell: |
| Address: |
| In general, the HIPPA privacy rule gives individuals the right to request a restriction of their health information. The individual is also provided the right to request confidential communication of PHI (Protected Health Information) be made by alternative means, such as, sending information to the individuals office instead of their home.  I wish to be contacted in the following manner(check all that apply):  Home/Cell Telephone   * Ok to leave messages with details * Ok to speak to spouse/sibling   Work Telephone   * Ok to leave message with details * Leave message with call back   Written Communication   * Ok to mail to my home * Ok to fax to designated number   I give Dr. Burnett permission to use and disclose PHI necessary to carry out TPO(Treatment payment or Operations). This is also indicated a “Good Faith Effort” was made on behalf of Dr. Burnett. By signing this form, I understand that the privacy practices of this office have been disclosed to me. This information will stay on record for six years.  Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |